TREATMENT RECOMMENDATIONS

CLIENT'S NAME

SECTION 8

A. TREATMENT RECOMMENDATIONS

DIMENSION RESULTS

Dimension 1 .....Level: _____ **Dimension 3 .....Level: _____** **Dimension 5 .....Level: _____**

Dimension 2 .....Level: _____ **Dimension 4 .....Level: _____** **Dimension 6 .....Level: _____**

B. LEVEL OF CARE RECOMMENDED PER ASAM

☐ Level 0.5 Early intervention
Evidenced by: _____

☐ Level OMT Opioid maintenance therapy
Evidenced by: _____

☐ Level I Outpatient
Evidenced by: _____

☐ Level II.1 Intensive Outpatient
Evidenced by: _____

☐ Level II.5 Outpatient with partial hospitalization
Evidenced by: _____

☐ Level III.1 Clinically managed low intensity residential services
Evidenced by: _____

☐ Level III.3 Clinically managed medium intensity residential service
Evidenced by: _____

☐ Level III.5 Clinically managed medium/high intensity residential services
Evidenced by: _____

☐ Level III.2 - D Clinically managed residential detoxification subacute detox
Evidenced by: _____

☐ Level III.7 Medically monitored intensive inpatient services - detox
Evidenced by: _____

☐ Level OMT Opioid maintenance therapy
Evidenced by: _____

☐ Level IV Medically managed intensive inpatient services, detox or hospital
Evidenced by: _____

C. OVERRIDES

1. Are there any circumstances which would override placement at any level of care (i.e., legal mandates, logistical barriers to treatment, lack of intensive inpatient, recent treatment failure or need for extended assessment, inpatient aversion therapy, etc.?

   ☐ Yes ☐ No If yes, explain:

2. Also recommended: ☐ Domestic Violence Perpetrator Program ☐ Anger Management ☐ GED
   ☐ Division of Vocational Rehabilitation ☐ Mental health counseling
   ☐ Literacy Tutor Program ☐ Self help groups

3. Client has been informed of assessment results: ☐ Yes ☐ No

4. Client was not informed of assessment results due to:

D. MISCELLANEOUS

1. Does the client need detox prior to treatment? ☐ Yes ☐ No If yes: ☐ Acute ☐ Sub-acute
2. Does the client need part time or around the clock child care in order to access treatment? ☐ Yes ☐ No
3. Does the client need help accessing/selecting the child care? ☐ Yes ☐ No

E. BRIEF RISK HIV/AIDS NOTIFICATION

HIV/AIDS brief risk intervention done? ☐ Yes ☐ No

COUNSELOR MUST INITIAL AND DATE TO INDICATE COMPLIANCE.

Counselor's initials: Date: